

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-050475

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 325 Primary Registration District No. 4480 Registrar's No. 141

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

FILED DEC 20 1963

1. PLACE OF DEATH a. COUNTY SCHUYLER		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI COUNTY SCHUYLER	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN GREENTOP		c. CITY OR TOWN LANCASTER	
Length of stay in 1b 4 YR.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION HAVEN OF REST NURSING HOME		d. STREET ADDRESS (If outside, give location) NONE	
Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First LULA Middle MAE Last MARTIN			4. DATE OF DEATH Month December Day 11, Year 1963		
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5. SEX F	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10/8/1881	9. AGE (last birthday) 82	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Months Days Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY housewife	11. BIRTHPLACE (City and state or country) SCHUYLER COUNTY	12. CITIZEN OF WHAT COUNTRY U.S.A.
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13a. FATHER'S NAME TOWNSEND HEATON	13b. MOTHER'S MAIDEN NAME NANCY J. HALE	14. NAME OF HUSBAND OR WIFE FLEM MARTIN
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) NO	16. SOCIAL SECURITY NO. [REDACTED]	17. INFORMANT HERBERT MARTIN, 7200 Hiway #2, Commerce City, Colo.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure DUE TO (b) Hypostatic Pneumonia DUE TO (c) Cerebral Thrombus		INTERVAL BETWEEN ONSET AND DEATH 2 days 3 days 1 week
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Metastatic Carcinoma of Right Breast		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from 8/20/60 to 12/11/63 and last saw her alive on 12/10/63	
Death occurred at 11:20A m on the date stated above, and to the best of my knowledge, from the causes stated.	

22a. SIGNATURE Edward M. Roberts M.D.	22b. ADDRESS Queen City, Mo.	22c. DATE SIGNED 12/18/63
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 12/13/1963	23c. NAME OF CEMETERY OR CREMATORY DARBY CEMETERY	23d. LOCATION (City, town, or county) N/E of Lancaster, Mo.
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24. FUNERAL DIRECTOR Norman Funeral Home, Lancaster, Mo.	25. DATE RECD. BY LOCAL REG. Dec. 18, 1963	26. REGISTRAR'S SIGNATURE [Signature]
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USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DATE AMENDED

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

VS 300  
Rev. 4/59  
10980  
20980  
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4 1  
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6  
7 0  
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9322XH  
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13 1-0

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

-Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Norm E. Foster*

Licensed Embalmer No.

*47429*

P. O. Address

*Furkane, Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.